



Seeking
Common
Ground:

Demographic
Goals and
Individual
Choice

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THE EVOLUTION OF POPULATION CONCERNS

When the international family planning movement began forty years ago, its central rationale was to enable individuals, especially women, and couples to exercise control over their own reproduction. Individual well-being and quality of life received top priority. Beginning in the 1960s, as governments gradually became more and more concerned about rapid population growth, the national perspective came to override the individual perspective. Particularly in Asia, the explosive rate of population growth caused governments to worry increasingly about their ability to provide adequate levels of health, education, and other social services, as well as to keep food production on a par with demographic increase.

Donor countries also began to push policies and aid programs designed to reduce population growth rates.

Leaders such as former U.S. president Lyndon Johnson and Robert McNamara, as president of the World Bank, called population growth one of the most serious problems facing the world and deemed investments in family planning among the most cost effective in the development field.

At the same time, governments, worried that individual motivation to limit family size was not sufficient to bring about fertility decline of a magnitude they deemed necessary for development, began to include population variables in their centralized planning processes. To guide the expansion of family planning programs, many countries, especially in Asia, developed fertility targets, which were sometimes translated into quotas or targets for individual providers.

DEVELOPMENT VERSUS FAMILY PLANNING

Some demographers and other social scientists of the day were also dubious that voluntary family planning programs alone would be sufficient to stem the high rates of population growth.¹ Thus, the great debates of the 1960s and 1970s: development versus family planning, and voluntarism versus direct interventions to influence reproductive behavior. To a considerable degree, these debates were the result of inadequate understanding — a lack of information about how much fertility was unwanted and how rapidly reproductive desires would change if family planning information and services were provided.

The pessimists, some of them famous names in demography and economics, developed strong and persuasive theories about why the poor and the uneducated, living on the margin of subsistence, should want large families. Family planners, on the other hand, saw substantial demand wherever good services were available. However, their position was less successful in the struggle for policy preeminence.

The economic determinists carried the day at the Bucharest World Population Conference of 1974. Their position, that structural social and economic conditions must change if fertility is to decline, prevailed in the form of such phrases as “development is the best contraceptive” and “take care of the people and population will take care of itself.” This encouraged ambivalence about organized family planning programs on the part of some governments. Their sense was that population growth would decline if they could achieve success in overall poverty reduction and improvements in the social sectors, particularly primary health care and basic education.

A few governments, pessimistic about the efficacy of voluntary family planning as a means to reduce population growth yet still afraid of the consequences of rapid growth, imposed policies that were to a greater or lesser degree coercive. These policies, often implemented in clumsy and heavy-handed ways, produced severe backlashes in a few places as citizens' organizations reacted angrily to efforts to compel adoption of particular methods of family planning. A revulsion against administratively set

targets and field-worker quotas emerged. Whichever approach was taken — social and economic development programs that would reduce desired family size, or direct interventions to change reproductive behavior — it went forward with considerable uncertainty about the desire of individuals to have smaller families and a lack of confidence about how people would behave given the option of full and convenient access to family planning services.²

DEMAND FOR FAMILY PLANNING

The World Fertility Survey (WFS) and the Demographic and Health Surveys (DHS) have helped change perceptions concerning demand for family planning. The internationally comparable data produced by these research programs have shown a significant level of unwanted fertility in almost all countries — a level too high and too consistent over time to be due to unreliable expressions of fertility preferences. Furthermore, the fertility preferences and demand for family planning services revealed by these surveys have proved to be remarkably strong predictors of subsequent contraceptive and fertility behavior in all the



countries in which they have been conducted.³ As a result of these survey programs, it is no longer necessary for governments to operate in ignorance. They now have data available to them on unwanted fertility and on people's desire to control it.

In addition, despite the debates going on in academic circles and the doubts within some developing-country governments, highly effective family planning programs were implemented in many countries around the world, for example in Taiwan, Korea, and Colombia, beginning in the 1960s, in Mexico, Indonesia, and Thailand during the 1970s, and in Zimbabwe, Bangladesh, and Kenya during the 1980s. Both government and private organizations contributed to these and other successes, which were not always on a national scale. Analyses of the successful efforts highlighted common traits — policy support, good management, cultural sensitivity and high-quality, client-centered services.

Thus, understanding of population issues improved dramatically on two fronts:

1. the magnitude of people's desire to control their fertility, and

2. the policies and program elements necessary to deliver high quality services.

RENEWED ATTENTION TO RAPID GROWTH

At the same time that news about the expanding demand for and use of family planning was spreading within the development community, the environmental movement, building up to the Earth Summit at Rio in 1992, was renewing global calls for action on population growth. The environmental movement saw the rapid growth in human numbers as one of the fundamental factors that had to be addressed if environmental sustainability were to be achieved.

The concern of the environmentalists reawakened the fear of women's groups and others that had reacted to the heavy-handed demographic policies in some countries in the earlier era. After two decades of effort to shift the rationale for family planning from macro-demographic considerations to individual choice and rights, many of these groups feared that a new demographic imperative would produce a

wave of aggressive population policies and massive low quality family planning efforts. They feared that programs would force people to limit their childbearing and that little effort would be invested in trying to improve the quality of services.⁴

A NEW APPROACH TO PLANNING

Population growth affects every aspect of the development process, and reproductive change is key to socioeconomic change. Yet the valid concerns that a renewed demographic agenda will be bluntly carried out, focusing on targets determined in isolation from people's felt needs and sensibilities, could lead to a hesitation to learn from and build on past family planning successes. The recent WFS and DHS data highlight the need for improved and expanded family planning programs to meet individuals' fertility preferences. What if governments use this information as the base from which they begin their planning process, instead of using family planning targets derived from demographic modeling? Can the human (and humane) aspects of family planning programs be maintained and improved while additional progress toward

reducing population growth is realized? If achieving the goals of individual women and couples through voluntary family planning would produce the same or better demographic results as achieving targets set by governments, perhaps a common ground between those who advocate reproductive rights and those who stress the need for slower population growth can be firmly established.

Addressing the reproductive

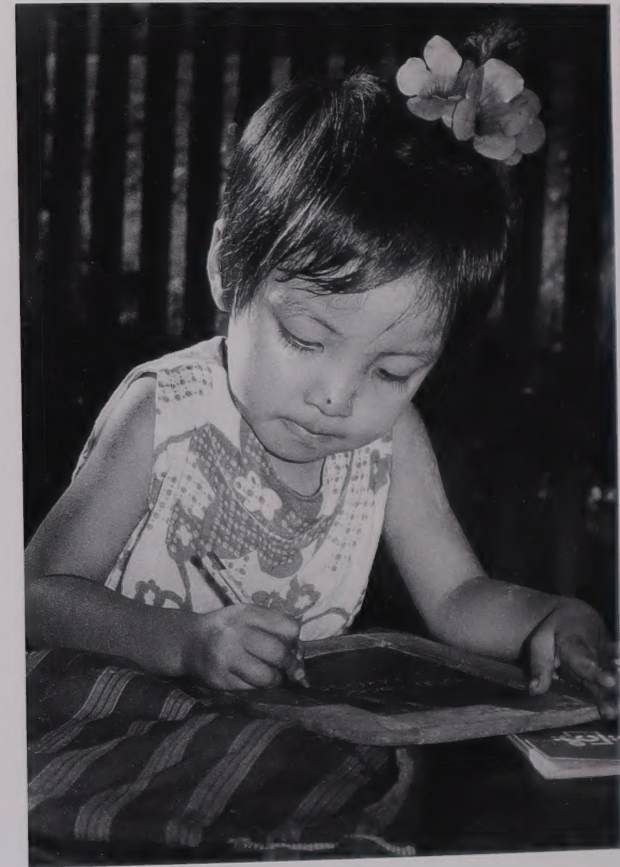
goals of individual women

and couples creates a common

ground between advocates

for reproductive rights and

those who stress the need for

slower population growth.


THE UNMET NEED FOR FAMILY PLANNING

WFS and DHS provide a solid data base from which to initiate a planning process based on individuals' fertility preferences. In addition to identifying the percentage of couples already acting on their preferences, i.e. those already practicing family planning, the survey data reveal a large pool of potential family planning clients whose needs are not being met. The size of this pool can be measured using the concept of unmet need.⁵ Various definitions have been used, but the basic sense is that many married women who say they do not want a pregnancy, either soon or ever, are not yet using a contraceptive method. This is a conservative definition, used here in order to provide a consistent series of data. Besides being comparable across numerous countries, this measure is, in a general sense, representative of the size of the potential clientele for family planning

services beyond those women and men already being reached. It does not, however, address the issue of the content or the quality of services. Recently other analysts have argued for enlarging the concept, stressing that unmet needs also exist among the unmarried, among users whose method is unsafe, ineffective, or unsuitable, and among those with unwanted pregnancies who lack access to safe and affordable abortion.⁶ A broader definition of unmet need that tried to incorporate these issues would certainly expand the size of the pool (see box on page 10).

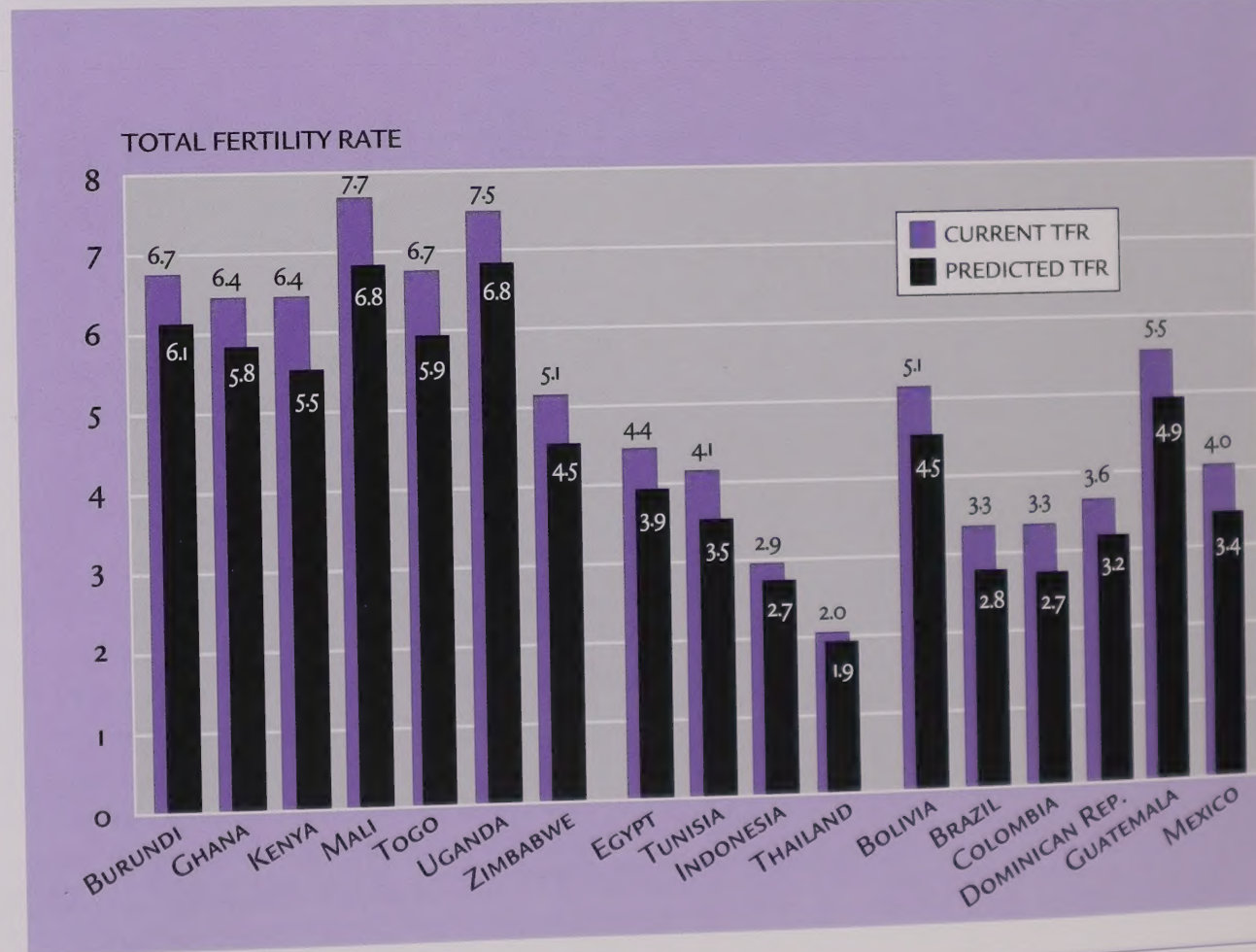
The Annex on pages 19 and 20 provides data on unmet need for family planning in 35 countries around the world. The size of this potential pool of family planning acceptors ranges from 12 percent in Indonesia, Sri Lanka, and Thailand to 41 percent in Togo, and is

generally higher in countries with the highest fertility, which also tend to be the least developed. Even though total demand* for family planning tends to be lower in such countries, they have nonetheless done less to address the unmet-need component. Sub-Saharan Africa lags far behind Asia, North Africa, and Latin America in the proportion of need that is unmet.

What impact could meeting unmet need have on a country's fertility rate? Based on DHS data, Figure 1 shows the decline in fertility that could be expected five years after the survey if respondents' statements about future fertility intentions were realized. In Africa, despite the relatively high fertility rates, a number of countries show significant prospective declines. Indeed, some of the African countries (e.g. Kenya, Mali, Togo, and Uganda) show prospective declines that equal or exceed those of lower fertility countries in which family planning services and information are already much better established, like those in North Africa and Latin America. (The prospective declines in Asia are quite low because of comparatively high contraceptive use and low fertility rates in those countries.)

* Total demand for family planning has two components: (1) current contraceptive use and (2) unmet need.

FIGURE 1. CURRENT AND PREDICTED† TOTAL FERTILITY RATE (TFR)



†Five years after each country's Demographic and Health Survey, if unmet need were addressed.
Source: Demographic and Health Surveys 1986-1989.

SATISFYING UNMET NEED VERSUS ACHIEVING TARGETS

The previous section reviewed the extent of unmet need. Figure 2 compares the demographic effect of meeting unmet need with the effect of achieving targets stipulated by the government, converted where necessary to contraceptive prevalence rates (CPR).^{*} The countries listed on Figure 2 are those that have both recent survey data and quantitative demographic targets, according to UN and other sources.

The last column on Figure 2 compares the demographic targets with total demand. A positive number indicates that the satisfaction of unmet need would result in a contraceptive prevalence rate higher than that which would be achieved by meeting the demographic target. For example, in Tunisia, with a target CPR of 51 percent and an actual CPR of nearly 50 percent in 1988, meeting the target would raise prevalence by only 1 percent, whereas satisfying unmet need

would result in a 15.7 percent increase. Thus, the number in column 4 is 14.5.

In 13 of the 17 countries, satisfying unmet need would exceed the government targets by amounts ranging from 1 to 31 percent. In India, the unmet need figure is based only on desire to terminate childbearing; if the ratio of spacers to limiters is taken to be the same in India as in the Asian region, its unmet need rises from 18.3 to 31.2 and satisfying it would raise prevalence well above the target. Nigeria and Ghana have targets whose realization would require more than simply satisfying expressed need for family planning, and in both of these countries service availability is still severely constrained.

^{*}Countries present targets in various forms. For Figure 2, if the target is stated as a fertility measure or a crude birth rate (CBR), it was converted to the corresponding level of contraceptive prevalence. The equations used for the relation of prevalence to the CBR and the TFR are based upon international correlations: $TFR = 7.03 - (.0662) \text{ (Prevalence)}$ or $CBR = 46 - (0.42) \text{ (Prevalence)}$. In a few cases the target was stated as either the net or gross reproduction rate. UN projections were used to show the relation of those measures to the TFR for the same future dates. Then the TFRs were converted to prevalence by the above formula.

FIGURE 2. COMPARISON OF TARGETS AND UNMET NEED

Country	Date of Prevalence and Unmet Need	Prevalence (1)	Unmet Need** (2)	Date of Prevalence Target	Prevalence Target (3)	Excess Need Over Target*** (4)
Latin America						
Haiti*	1989	10.0	27.0	2000	60.0	-23.0
Jamaica*	1989	55.0	20.0	2000	74.5	0.5
Mexico	1987	52.7	24.1	2000	71.3	5.5
Peru	1991-92	59.0	16.0	1995-2000	61.0	14.0
Sub-Saharan Africa						
Ghana	1979-80	12.9	26.6	2000	46.0	-6.5
Kenya	1989	26.9	28.9	2000	40.0	15.8
Mauritius*	1985	75.0	3.0	1987	71.7	6.3
Nigeria	1990	6.0	20.8	2000	46.0	-19.2
Tanzania	1991-92	10.0	55.0	2000	31.0	24.0
Middle East and Northern Africa						
Egypt	1988-89	37.8	25.2	2000	60.0	3.0
Tunisia	1988	49.8	15.7	1991	51.0	14.5
Turkey*	1988	60.0	19.0	1995-2000	62.5	16.5
Asia						
Bangladesh	1991	39.9	41.0	1995	50.0	30.9
India	1988-89	43.0	18.3	2000	60.0	1.3
Indonesia	1987	47.8	13.0	N/A	55.0	5.8
Pakistan	1990-91	11.9	28.0	1998	29.0	10.9
Thailand	1987	65.5	11.1	1991	79.4	-2.8

* Taken from "Family Planning Surveys" in Robey et al., which base unmet need on fecund, sexually active women regardless of marital status, whereas DHS surveys base unmet need only on women who are married or cohabitating. India: unmet need includes only those wishing to limit childbearing; it omits those wishing to space. Nigeria: amenorrhoeic women (nearly 30 percent of currently married women) are excluded from calculations of current unmet need. Tanzania: unmet need is estimated approximately as follows: of married women, ages 15-49, 42 percent wish to space (over two years) and 23 percent wish to limit, for a total of 65 percent. Of these, ten percent are using (any method), leaving 55 percent in need. Infecund and don't know responses excluded. See Tanzania DHS Survey 1991-92, tables 5 and 7.

**Where unmet need estimates differ between Bongaarts, and Westoff and Ochoa, the more conservative (lower) Bongaarts figure is used.

***Columns (1) + (2) - (3) = (4)

Source: See Reference 7, inside back cover.

DEFINITIONS OF UNMET NEED FOR FAMILY PLANNING

"Unmet need" has become a common way to estimate family planning resource needs. Researchers, however, define the term in various ways. As a result, the level of unmet need for family planning varies according to the stringency of the definition being used.

Charles Westoff & Colleagues

The originators of the term, Charles Westoff and colleagues working primarily with data from the Demographic and Health Surveys, have defined unmet need as the percentage of fecund married women not using contraception who are neither pregnant nor amenorrheic and say that they either want to postpone their next birth (spacers) or do not want to have any more children (limiters). Also included are pregnant or amenorrheic women whose current or latest pregnancy was unintended and who were not using contraception. Excluded are those whose pregnancies resulted from contraceptive failure. (See Annex on pages 19 and 20.)

John Bongaarts

John Bongaarts defines unmet need as the additional contraceptive use that would be required to reduce fertility levels to women's stated reproductive intentions and to eliminate all mistimed and unwanted pregnancies. In comparison to Westoff, he uses a broader category of women, including unmarried individuals and pregnant or amenorrheic women

whose current or latest pregnancy resulted from contraceptive failure. However, his estimates are generally lower because he makes two adjustments. The first takes into account that the satisfaction of spacing needs will reduce the unmet need for limiting because the women will be older at the time they complete their desired fertility and will accordingly be exposed to the risk of an unwanted birth for a shorter period of time. The second adjustment takes into consideration that current spacers will eventually deliberately stop contracepting in order to have a child. As a result, Bongaarts' estimates, based on 15 countries, show an average unmet need of 17 percent while Westoff's method yields a 21 percent average.

Centers for Disease Control (CDC)

The Centers for Disease Control Family Planning Survey (FPS) defines unmet need as the percentage of fecund, non-pregnant, sexually active women regardless of marital status who are not using contraception even though they do not currently want to become pregnant. FPS data on unmet need are not divided into "spacing" and "limiting" components, nor do they include women who become pregnant unintentionally. DHS and FPS provide similar unmet need estimates.

Women's Health Advocates

Women's health advocates such as Ruth Dixon-Mueller and Adrienne Germain have argued for a much broader definition

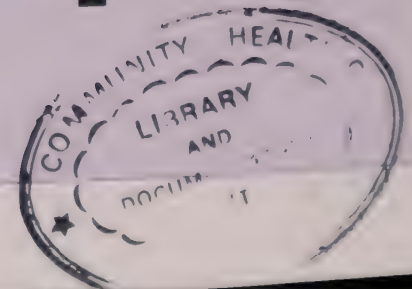
of the concept. Building on the conventional definition (Westoff's), they propose an approach that also includes women who are unmarried; those who are currently using some form of contraception which may be unsafe, ineffective, or unsuitable; those who are using contraceptives incorrectly or sporadically; and those with unwanted pregnancies who lack access to safe, affordable abortions. Users and nonusers who need more comprehensive sexual and reproductive health services are also included. This approach has not yet been quantified.

Employing a similar definition, the International Planned Parenthood Federation (IPPF) estimates that the number of those with an unmet need for high-quality family planning services worldwide runs into hundreds of millions. Along the same vein, the World Health Organization (WHO) estimates that 300 million couples in the world who do not want more children are still not using any form of contraception. In calculating this figure, WHO takes into consideration that many couples lack easy or regular access, and additional individuals are not users because of access difficulties. By so doing, the organization estimates that less than one-third of all couples are within easy reach of family planning services.

VARIOUS CATEGORIES OF WOMEN TAKEN INTO ACCOUNT WHEN ESTIMATING UNMET NEED

	Marital Status	Spacers*	Limiters**	Unwanted Pregnancy (pregnant or amenorrheic: non-use of contraception)	Unwanted Pregnancy (contraceptive failure)	Nonusers & Users with Unwanted Pregnancy Who Lack Access To Safe Abortions	Users of Ineffective, Unsafe or Unsuitable Methods	All in Need of Comprehensive Sexual and Reproductive Health Services
DHS (Westoff)	Fecund, married women	■	■	■				
Bongaarts	Fecund couples or unmarried individuals	■	■	■	■			
CDC Family Planning Survey	All women: fecund, not pregnant, & sexually active	■	■					
Women's Health Advocates (Germain & Dixon-Mueller)	All fecund persons	■	■	■	■	■	■	■

*Spacers are women who want to postpone the next birth by at least two years from the time they are interviewed.
 **Limiters are women who want no more births.



THE GLOBAL PICTURE

Contraceptive use in developing countries has expanded dramatically since 1960, but the total number of women not using any form of contraception has hardly declined at all, due to the enormous expansion in the number of women in the reproductive age group. Projections to the year 2025 show that, even though the number of women estimated to be using contraception again expands quite dramatically, the number of women not using contraception is still large (see Figure 3). This illustrates the enormous challenges to expanding contraceptive coverage if replacement-level fertility — the level at which population would eventually stop growing — is to be even approached in the first quarter of the next century.

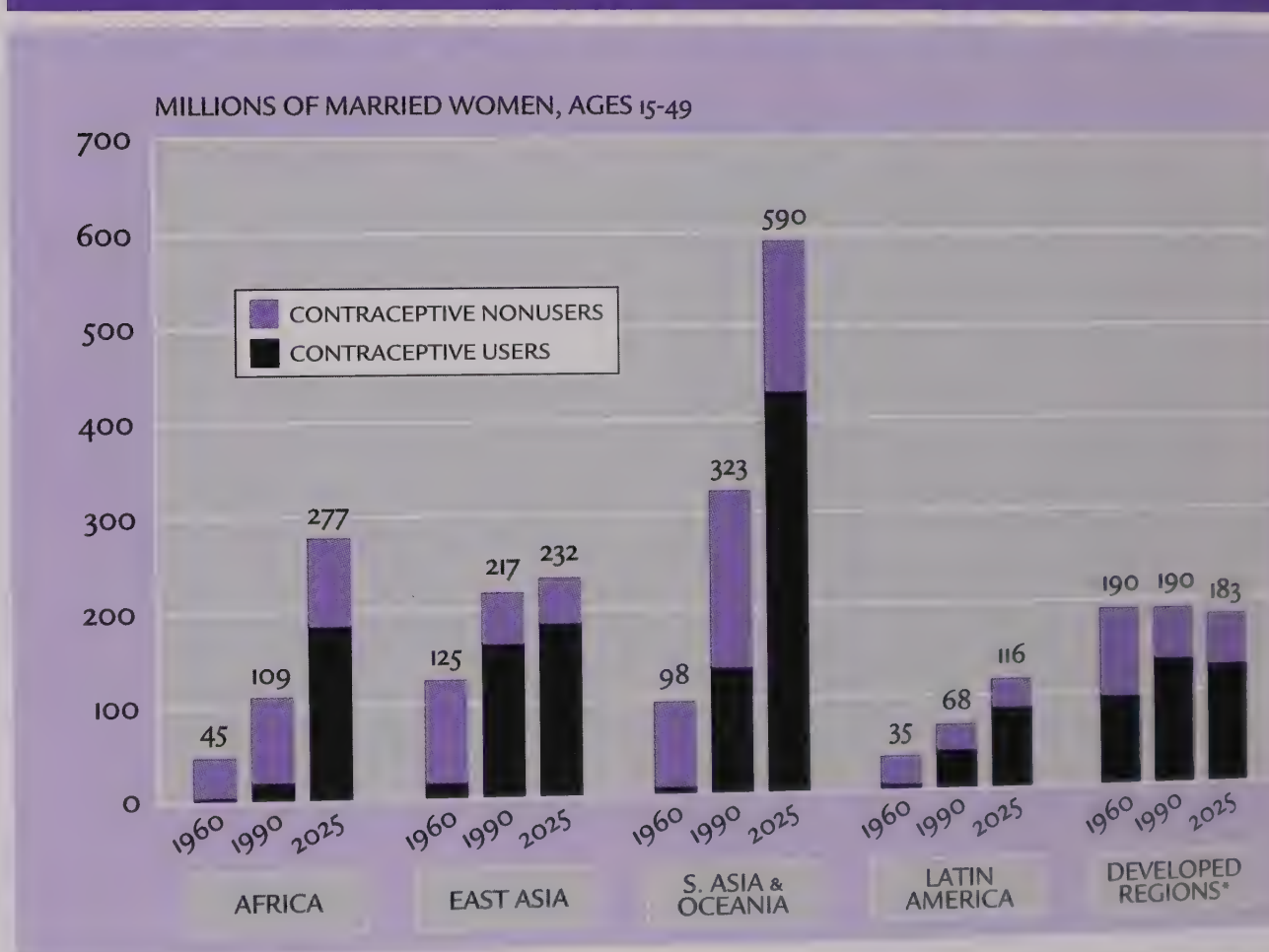
As highlighted above, in many countries meeting unmet need could have dramatic results. What would the

effect on global population growth be if the unmet need for family planning were met? A conservative global estimate is that approximately 17 percent of the women in the developing world outside of China — about 100 million women — presently have an unmet need for contraception.⁸ International data show that a 15 percent addition to the CPR is associated with a decline of about one child per woman in the TFR, so satisfying the 17 percent unmet need could reduce the TFR in developing countries by 1.13 children. In 1993, the TFR in the developing world, excluding China, was an estimated 4.40 children per woman.⁹ Meeting unmet need would bring that figure down to 3.27. The fall from nearly four-and-a-half to three-and-a-quarter births per woman is half way toward replacement-level fertility of approximately 2 births per woman.

How feasible would it be to meet even the conservative estimate of 17 percent unmet need? The task is made more difficult by the time it would take, during which the number of reproductive age couples will grow. To minimize the compounding impact of population growth, could unmet need be addressed quickly? A 17-point rise in, say, six years, to the year 2000, would mean an increase of 2.8 points per year, an impossibly high figure by historical standards. (Repeat surveys in 49 developing countries give an average increase of 1.5 points in prevalence per year, over an observation period averaging 12 years. The range is from nearly zero to about 2.5). Thus, a six-year perspective is too short. However, if prevalence rose by 1.5 points a year, a prevalence rate of 57 could be achieved in ten years. This exceeds the contraceptive prevalence "target" of 56 percent agreed to in the 1989 Amsterdam Declaration.¹⁰

A focus on unmet need can guarantee neither that all women's reproductive health needs will be met quickly nor that fertility will decline rapidly. Of course, the same must be said of targets: many have not been

FIGURE 3. ESTIMATED CONTRACEPTIVE USE: 1960, 1990, AND 2025



*Japan, Australia, and New Zealand are included in developed regions not East Asia and Oceania respectively
 Source: UN, *Levels and Trends of Contraceptive Use* (tables 5, 7 & 8) (1989), and UN, *World Population Prospects The 1992 Revision* (table A. 18) (1993).



met, either at all or on schedule. Both approaches require expansion of high-quality services, including outreach to the underserved, improved contraceptive technology, and higher programmatic standards. They differ however in their assumptions and in their approaches to the public — crucial differences that affect the efficacy and acceptability of family planning.

On average, in the developing

world, meeting unmet need would

lead to a reduction in fertility

from today's level of nearly

four-and-a-half births per woman

to three-and-a-quarter births.

This is half way toward

replacement-level fertility.

THE HEALTH BENEFITS OF ADDRESSING UNMET NEED

De-emphasizing targets could help alleviate another prevailing tension, that between population and health programs. Advances in contraceptive protection and advances in child survival are mutually supportive: reduced infant mortality encourages birth planning and fertility decline, and increased contraception improves child survival. With expanded use of contraception and access to safe abortion, there are fewer pregnancies and births, leading automatically to fewer unsafe abortions, infant deaths and maternal deaths in terms of absolute numbers. In addition, infant and maternal mortality rates decline because there are fewer high risk births, particularly births spaced less than two years apart. This is especially important in the African context, where much of the unmet need for family planning is

related to birth spacing. There are also nutritional and other gains that raise the quality of life for the child, not to mention the advantages to the mother and family from the lessened burdens of excessive fertility.¹¹

An estimated 14 million infants and children under age five die each year, most from essentially preventable causes.¹² Despite this shockingly high number, infant and child mortality rates have declined significantly over the past few decades because of several health initiatives, including oral rehydration therapy (ORT) and the expanded program of immunization (EPI). The positive benefits of these efforts can be enhanced by addressing the unmet need for family planning. Child survival and family planning efforts are mutually reinforcing because



the potential client families are often the same for both programs.

Maternal mortality is dramatically higher in developing countries than in the industrialized West: WHO estimates that maternal deaths range from 100 to 1,000 per 100,000 live births, ratios that are 10 to 100 times those in the U.S. and Europe.¹³ More maternal deaths occur in India in one week than in all of Europe in an entire year. Many of these deaths occur in village settings from causes that are relatively immune to local measures, causes that cannot easily be relieved except through formal health services that are unfortunately absent. Thus, pregnancy prevention emerges as a vital service to reduce maternal mortality. One study, using WFS and DHS data, estimates that between 17 and 35 percent of maternal deaths might be prevented if all women who wanted no more children used reliable contraceptive protection.¹⁴

Rarely are there examples, as is the case with family planning, where one program initiative can have a significant impact on two major policy objectives. The voluntary use of contraception by all women and couples who wish to avoid pregnancy, whether soon or ever,

would yield very large health benefits to both mothers and children, and would go far toward meeting the societal need for lowered population growth rates. A strong rationale thus exists for the two movements to join forces. De-emphasizing targets should pave the way to a more fruitful collaboration — one that, based on the evidence, would advance both sets of interests.

Family planning is one of the

few programs that can have a

significant impact on two major

policy objectives — improved

reproductive health and slower

population growth.

IMPLICATIONS

Survey data indicate that a very significant impact would result from family planning and health programs that focused more closely on the stated reproductive preferences of individual women in the developing world. In fact, the data strongly suggest that such an approach would achieve as much, or more, demographically than meeting most countries' demographic targets. The policy implication is clear: replace demographic targets with goals expressed in terms of fully addressing the stated desires of the people served.

Though better, a focus on unmet need will not necessarily be easier in a programmatic sense. The reasons why some women who state a desire to control their fertility do not do so are complex: they may fear rumored side-effects from contraceptives; they may believe their

husbands disapprove; they may face familial pressure to have additional children; they may have had negative experiences with family planning programs in the past. In addition, the expansion of programs, which in some countries would have to be extensive, cannot be done without major organizational effort. Many people will continue to lack access to high quality contraceptive services unless program structures are substantially strengthened, including, in some cases, modifications of the organizational culture of programs, in supervisor-worker relationships, and in provider attitudes toward their clients.

There is no one detailed blueprint for countries that want to adapt their approaches to an unmet need focus. Policymakers and program

planners in each country would need to assess the level of unmet need, in various age groups, for birth spacing and limiting. Then, they would need to examine their current delivery systems to see which components needed strengthening. The experience of successful family planning programs makes it clear that better results will be achieved by stressing high-quality services rather than relying upon aggressive targets combined sometimes with limited contraceptive options and defective services. Quality programs include culturally appropriate information campaigns, well trained staff and counselors, field approaches oriented to those desiring assistance, and a variety of method choices, conveniently available close at hand.

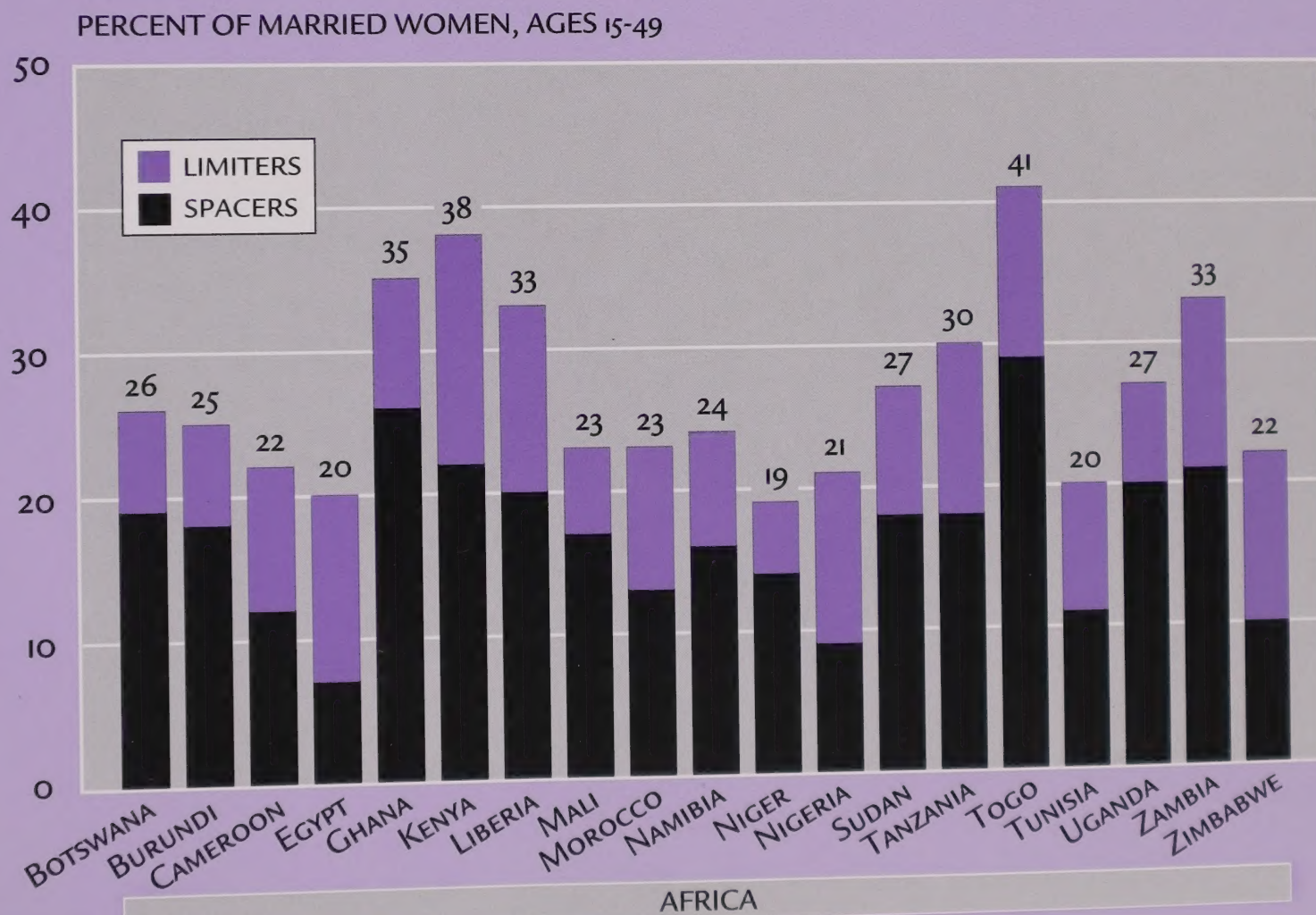
Finally, all this does not by any means suggest that the provision of family planning services is the only thing that needs to be done to achieve replacement-level fertility and eventual population stabilization. Clearly, continued intensive efforts to enhance the conditions of women, alleviate poverty, raise educational levels, and improve living standards in developing countries will be required if desired family size is to coincide eventually

with replacement-level fertility. But, it is equally clear that improved access to quality reproductive health services for all who have stated a need for those services will carry the world a very long way toward replacement-level fertility, while efforts to promote social and economic progress continue to create conditions that favor smaller desired family size.

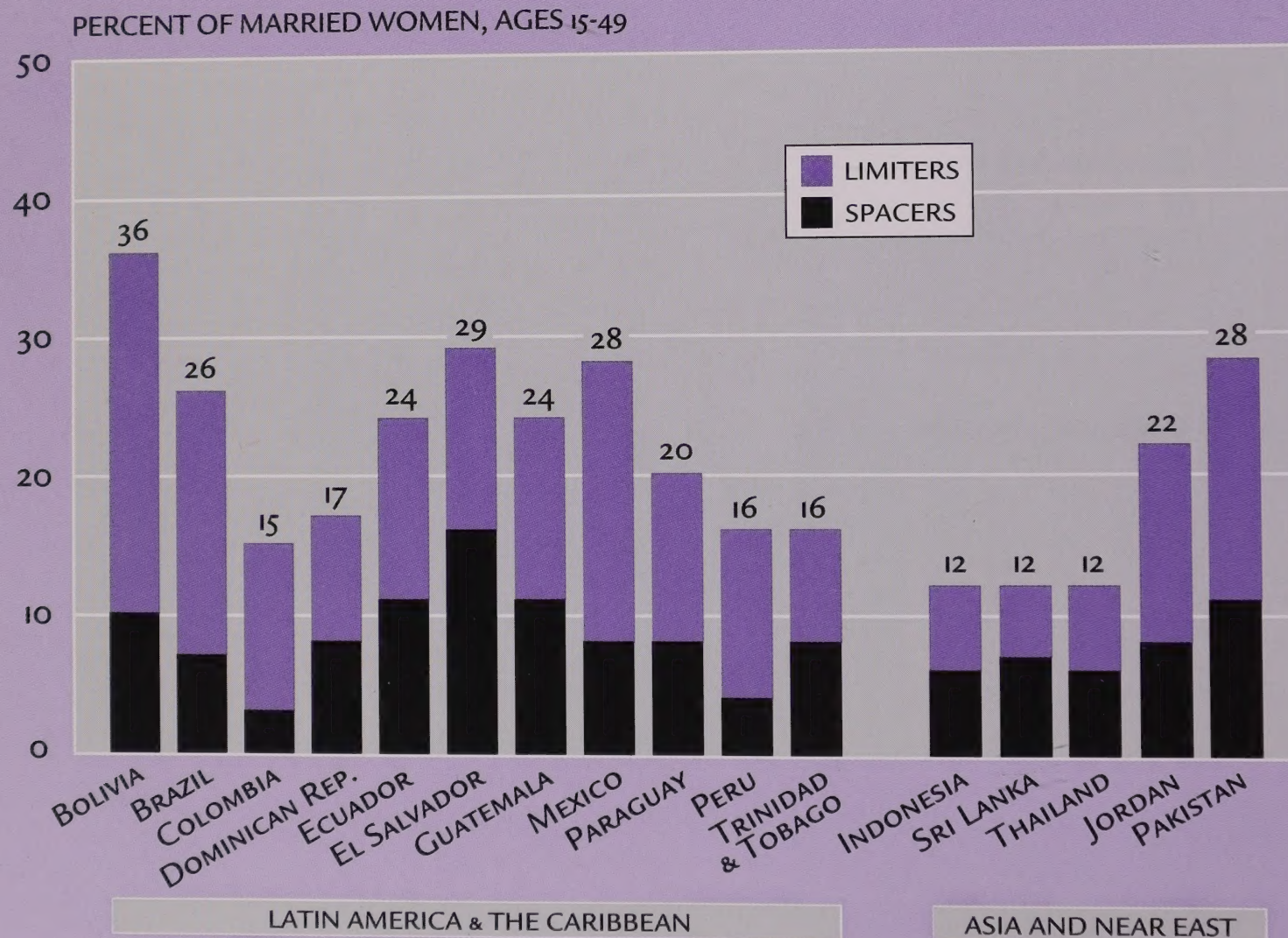
In short, while it is quite appropriate for countries to set long-term demographic objectives in the context of a comprehensive development strategy (one that includes raising literacy, enhancing educational opportunities for women, lowering infant mortality, and improving maternal and child nutrition), it is neither desirable nor necessary for those objectives to be applied as targets for family planning acceptance. Addressing the unmet need for family planning could go a long way toward a reconciliation between satisfying individual needs and achieving societal objectives — very good news for those who fear that targets encourage abusive family planning efforts and for those who, more generally, favor user-oriented, demand-driven service delivery programs.

*The experience of successful
family planning programs makes
it clear that better results will be
achieved by stressing high-quality
services rather than relying upon
aggressive targets combined
sometimes with limited
contraceptive options.*

ANNEX: ESTIMATED UNMET NEED FOR FAMILY PLANNING



ANNEX: ESTIMATED UNMET NEED FOR FAMILY PLANNING



Source: Westoff and Ochoa (1991) covering surveys from 1987-1991, and DHS Indonesia Report (1991).

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